



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

DR. WILLIAM PASLAK

Respondent Name

ACE AMERICAN INSURANCE CO

MFDR Tracking Number

M4-14-3515-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

JULY 29, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are re-submitting a claim for the above mentioned claimant. We billed the attached \$1200 in February of 2014 with 16 units of CPT code 97750, but the MAR was not paid because this service was bundled with another service performed on the same day...We are now submitting a corrected HCCFA 1500 with modifier -59 to indicate that the services performed to complete the carrier's DD request were distinct or independent, but appropriate under the circumstances."

Amount in Dispute: \$1,200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the MDR, the bill was sent for additional review. It was determined that no additional payment is owed to the provider."

Response Submitted By: ACE/ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 4, 2014	CPT Code 97750-FC (16 units) Functional Capacity Evaluation (FCE)	\$1,200.00	\$799.04

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 082-Per national Correct Coding Initiative Edits, this code is not separately reimbursable.
 - CCI Comprehensive/Component Procedure.
 - 236-This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the NCCI edits or work comp state regs/fee schedule requirements.

- Previous recommendation history.
- 4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 402-The appropriate modifier was not utilized.
- 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the allowance for the disputed FCE bundled into the allowance of another service rendered on the disputed date of service?
2. Did the requestor bill for the FCE in accordance with 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to additional reimbursement for the FCE rendered on February 4, 2014?

Findings

1. According to the explanation of benefits, the carrier denied reimbursement for the disputed FCE based upon reason codes "082", "236", and "97".

On the disputed date of service, the requestor billed the respondent for codes 99456-WP (Maximum Medical Improvement and Impairment Rating), 99456-RE-W8 (Return to Work Evaluation), 99080-73 (Work Status Report) and 97750-FC-59 (Functional Capacity Evaluation).

28 Texas Administrative Code §134.204(d)(5) states "If the examination for the determination of MMI and/or the assignment of IR requires testing that is not outlined in the AMA Guides, the appropriate CPT code(s) shall be billed and reimbursed in addition to the fees outlined in paragraphs (3) and (4) of this subsection."

28 Texas Administrative Code §134.204(k) regarding return to work evaluations states in part "Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

The Division finds that per 28 Texas Administrative Code §134.204(d)(5) and (k), the FCE is not bundled to any service billed on the disputed date of service.

2. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204.

On the disputed date of service, the requestor billed CPT code 97750-FC-59.

The American Medical Association (AMA) Current Procedural Terminology (CPT) defines CPT code 97750 as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."

The requestor appended modifier "FC" to code 97750. 28 Texas Administrative Code §134.204(n)(3) states "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (3) FC, Functional Capacity-This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed".

The Division finds that the requestor billed the FCE in accordance with 28 Texas Administrative Code §134.204(n)(3).

3. 28 Texas Administrative Code §134.204(g) states "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required."

The requestor states in the position summary that the disputed FCE was requested by the Designated Doctor. A review of the submitted medical bill indicates that the requestor billed for sixteen units, which equals four hours; therefore, the requestor did not exceed the four hour limit set in 28 Texas Administrative Code §134.204(g) for Division ordered FCEs.

Per 28 Texas Administrative Code §134.204(g) to determine the reimbursement for FCEs the Division refers to 28 Texas Administrative Code §134.203(c)(1)(2).

Per 28 Texas Administrative Code §134.203(c)(1)(2), the following formula is used to calculate the Maximum Allowable Reimbursement (MAR): (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = MAR.

The 2014 DWC conversion factor for this service is 55.75.

The Medicare Conversion Factor is 35.8228.

Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 78574 which is located in Mission, Texas; therefore, the Medicare locality is "Rest of Texas."

The Medicare participating amount for CPT code 97750 is \$32.09.

Using the above formula, the MAR is \$49.94 per unit. The requestor billed for 16 units; therefore, \$49.94 X 16 = \$799.04. The respondent paid \$0.00. The difference between MAR and amount paid is \$799.04; this amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$799.04.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$799.04 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	04/24/2015 _____ Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.